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THE DIVISION OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

59-012694
STATE FILE NUMBER

FILED MAY 6 1959 Registration District No. 73 Primary Registration District No. 5291 Registrar's No. 57

1. PLACE OF DEATH
a. COUNTY: Clay
b. CITY OR TOWN: Liberty — Inside Limits: Yes ☐ No ☒
c. FULL NAME OF HOSPITAL OR INSTITUTION (If NOT in hospital, give location): Odd Fellows Home — Length of stay in 1b: 2 Yrs

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Missouri b. COUNTY: Clinton
c. CITY OR TOWN: Gower 0250 — Inside Limits: Yes ☒ No ☐
d. STREET ADDRESS (If outside, give location) — Reside on Farm: Yes ☐ No ☒

3. NAME OF DECEASED (Type or print): First: Mary Middle: E. Last: Bland

4. DATE OF DEATH: Month: March Day: 19 Year: 1959

5. SEX: female 1
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 2
8. DATE OF BIRTH: Feb. 16, 1872
9. AGE (In years last birthday): 87
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Work
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (City and state or country): Clay Co. Mo.
12. CITIZEN OF WHAT COUNTRY?: USA.

13a. FATHER'S NAME: Richard W. Berry
13b. MOTHER'S MAIDEN NAME: Nancy F. Scott
14. NAME OF HUSBAND OR WIFE: Henry F. Bland

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no
16. SOCIAL SECURITY NO.: none
17. INFORMANT: H. F. Bland Address: Gower, Mo.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH:
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c): HSECH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a): Mrs. Bland had ca breast removed in 1956
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐ 2

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐
20b. DESCRIBE HOW INJURY OCCURRED. (State nature of injury in PART I or PART II of item 18.): Removed
20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year
20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)
20f. CITY, TOWN, OR LOCATION COUNTY STATE

21. I attended the deceased from Jan 57, to _____ and last saw her/him alive on March 18 59
Death occurred at 6 A.M. on the date stated above; and to the best of my knowledge, from the causes stated.

22a. SIGNATURE (Degree or title): Wm. F. Goodson MD
22b. ADDRESS: Liberty Mo
22c. DATE SIGNED: 3/24/59

23a. BURIAL, CREMATION, REMOVAL (Specify): burial
23b. DATE: 3/21/1959
23c. NAME OF CEMETERY OR CREMATORY: Green Lawn Cemetery
23d. LOCATION (City, town, or county) (State): Plattsburg Mo.

24. FUNERAL DIRECTOR ADDRESS: John H. Murray Gower, Mo.
25. DATE RECD. BY LOCAL REG.: 4-27-59
26. REGISTRAR'S SIGNATURE: Mabel Graham

(Licensed Embalmer's Statement on Reverse Side)

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed.
All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by Me, Student Embalmer No. .....

working under my personal supervision.

Student .....
Signature of Student Embalmer

Signed John H. Murray

Licensed Embalmer No. 2893

P. O. Address Gower Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.